

Newcomer Health Program

Follow-Up Vaccine Form

Affix a patient label, or complete the information below:

Name: _____ **Web Vision /Patient ID#** _____

DOB: _____

Alien ID# _____

Health District: _____

Date vaccines administered: _____

Vaccines administered: ☐Td/Tdap ☐MMR ☐Varicella ☐Flu ☐Pneumococcal

Did your district complete the initial health screening for this patient? ☐Yes ☐No

If no, was the initial health screening completed in VA? ☐Yes ☐No

If the initial health screening was NOT completed in VA, where was it completed? _____

This form should be used whenever districts are providing additional vaccines (after the initial health screening) to refugees or other qualified individuals (asylees, etc.). Please provide all of the requested information above and fax to the NHP at (804)864-7913 along with your monthly org bills.

****Districts are reminded that the Newcomer Health Program is unable to provide reimbursement for costs associated with Hepatitis A or B vaccine for adults.**

***Costs associated with vaccines for children, including administration fees, should be billed to Medicaid.**